UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

SANDY J. BATTISTA, Plaintiff, v. HAROLD W. CLARKE, KATHLEEN M. DENNEHY, ROBERT MURPHY, TERRE K. MARSHALL, and SUSAN J. MARTIN, in their official and individual capacities; Defendants.	Civil Action No. 05-11456-DPW **Leave to File Granted on March 24, 2008**

REPLY TO DEFENDANTS' OPPOSITION TO
PLAINTIFF'S MOTION FOR A PROTECTIVE ORDER

Plaintiff Sandy J. Battista, through counsel, hereby submits her reply to Defendants' opposition to her motion for a protective order.

INTRODUCTION

In their effort to explain their requested dragnet into Ms. Battista's childhood medical, mental health, and disciplinary records, Defendants claim to need this information for a full assessment of her GID diagnosis. This is flawed on several levels.

First, this case is about whether the Defendants acted with deliberate indifference to Ms. Battista's medical needs, and in violation of her Constitutional and common law rights, by deciding not to follow the treatment plan prescribed by the DOC's contractual medical providers. It is not about whether an expert retained for litigation purposes might arrive at a different conclusion upon review of previously unavailable information. Defendants should not be allowed to use the discovery process to retroactively justify the challenged decision.

Second, though Defendants insists that their expert, Dr. Schmidt, must have access to the full panoply of Ms. Battista's entire life history in order to "evaluate" her diagnosis, Dr. Schmidt himself has previously testified that he neither requires nor relies on the kind of information Defendants now seek in the ordinary course of his clinical practice. Instead, Dr. Schmidt has testified that in the "typical" case he relies on the patient's self reports about his or her history, precisely the information that was available to Ms. Battista's medical providers and is currently available to the Defendants.

Third, even if Defendants were entitled to Ms. Battista' childhood medical records, they have provided absolutely no basis for interrogating Ms. Battista about the details of her abuse as a child and her mother's violent death. Interestingly, even Dr. Schmidt does not state in his affidavit that this rehash of traumatic childhood events is necessary for his analysis.[1] More importantly, even if the fact of these events were relevant, the Defendants and their expert are already in possession of all of the reports in which she has described these events to mental health professionals over the past 25 years, and have not identified a single additional fact it might learn from testing her current memory of these events.

Finally, the Defendants' insistence that its regulations do not provide a "private cause of action" misses the point. Ms. Battista alleges violations of her constitutional and common law rights on the basis that the Defendants unreasonably and in deliberate indifference to her medical condition interfered with treatment prescribed for her by their own contractual medical providers. The DOC has enacted regulations that set the standards for its own conduct, regulations which do not permit the Defendants to second guess medical decisions for reasons other than security concerns. Whether or not there is a "private right of action" under the

[1] Dr. Schmidt simply claims a need for a "personal interview" and access to records.

regulations, these regulations serve as the yardstick by which the Defendants' behavior is measured, and Defendants should not be allowed to use the discovery authority of this Court to go beyond what they are ordinarily entitled to do (i.e., to gather extensive new documentation in order to revisit the medical diagnosis) simply because a lawsuit has been filed.

I. Pre-Incarceration Medical, Mental Health, and Military Records Are Not Relevant

The central issue in this case is the DOC's calculated decision to deny Ms. Battista's prescribed medical treatment, and whether that decision violated Ms. Battista's rights. Defendants must justify that decision, if they can at all, based on the information available to them and their contractual medical providers at the time. Indeed, the Defendants' insistence on this discovery only highlights what is really going on in this case: GID patients, unlike any other inmate or resident of the Massachusetts Treatment Center seeking medical or mental health care, must go through the additional hoop of filing a lawsuit and subjecting themselves to onerous discovery in order to obtain a simple prescription ordered by the DOC's own contractual medical provider.

At bottom, the Defendants are seeking to justify their decision by starting the process of Ms. Battista's medical review and diagnosis anew, with this Court as the ultimate arbiter of the validity of the medical decision. Courts uniformly decline to second-guess the medical decisions of clinicians on a plaintiff's challenge to a medical diagnosis. *See Westlake v. Lucas*, 537 F.2d 857, 860 (6th Cir. 1976)("[F]ederal courts are generally reluctant to second guess medical judgments."); *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977)("[W]e disavow any attempt to second-guess the propriety or adequacy of a particular course of treatment."). This is so because the Court's role is to evaluate the Defendants' conduct, not to serve as a medical decision maker.

Likewise, there is no justification for the Defendants to recreate the medical record in an effort to have this Court second-guess the medical decisions of their own clinicians.

Similarly, the Defendants' reliance on a collection of evaluative reports from throughout Ms. Battista's incarceration as justification for more expansive discovery is misplaced. If anything, the reports demonstrate the breadth of the information already available to the Defendants at the time they made their decision, including 25 years of medical and mental health records during the period of Ms. Battista's incarceration and residency at the Treatment Center.

In short, the Defendants made their decision to withhold treatment based on the information available at the time of the decision and they cannot be allowed to bolster and justify that decision by a search at a later time for potentially supportive information – information that was not available to the providers recommending the treatment and which was not requested by the DOC until after this litigation commenced.

II. Defendant's Expert Affidavit Does Not Justify Their Discovery Requests

Even assuming relevance, the affidavit proffered by Defendants falls well short of demonstrating that the information sought is necessary to evaluating Ms. Battista's diagnosis and recommended treatment. In a nutshell, Defendants expert claims to need corroborating evidence of Ms. Battista's self reports of her history. There is no basis for this. In fact, Defendants' expert has described, under oath, the types of information on which he relies as a clinician in assessing GID patients:

> Q: Doctor, would you agree that the diagnosis of an individual for a Gender Identity Disorder is done primarily through the self-reports of the individual?
> A: Yes, as it, if you will, is filtered through the evaluation process done by a professional.
> …

Q: Doctor, when you examined an individual for -- a treatment for the symptoms of gender dysphoria, were there certain things that you looked for in your evaluation?
A. What we looked for -- yes, we look to their history for very specific things that help make the diagnosis.
Q. And, on occasion, do you ever seek a third-party to confirm the statements of the individual?
A. From time to time we've had the opportunity to have a -- family members, if you will, who can provide additional data and observations about the earlier history. ***But I would say the typical patient comes by himself and often they're the only source of the information***.

Exhibit 1 at 24-25 (Transcript from *Kosilek v. Dennehy*, June 7, 2006).

The medical professionals referenced by Defendants all relied on Ms. Battista's self-reporting in their evaluations, and Dr. Schmidt himself follows the same practice in assessing patients. Accordingly, even if Defendants were entitled to revisit the diagnosis with new evidence, years after the challenged decision was made, there is no basis for their apparent desire to have their retained expert apply an even more exacting standard to his review of Ms. Battista's diagnosis than he would use in his own clinical practice.

III. Ms. Battista's Traumatic Childhood Abuse and History Is Not Relevant

Just as the DOC's discovery requests for written records are not relevant, so too is any interrogation of Ms. Battista as to the childhood abuse she suffered or her mother's death at the hands of her father. First, for all the reasons set forth above, the Defendants have no right to recreate the record underlying their challenged decision, and therefore the details of Ms. Battista's trauma and abuse have no place in this case.

Second, even assuming relevance, the operative facts of all of these events are well known to the Defendants, as they are in possession of Ms. Battista's records since her time of incarceration over twenty years ago. Defendants have made no showing that knowledge of

further details of these events, even if Ms. Battista were able to remember them, would accomplish anything other than burdening and humiliating Ms. Battista.

CONCLUSION

For the foregoing reasons, Ms. Battista requests that the Court grant her motion for a protective order.

Dated: March 24, 2008

Respectfully submitted,

SANDY J. BATTISTA

By her attorneys,

/s/ Emily E. Smith-Lee
Emily Smith-Lee (BBO#634223)
Dana McSherry (BBO#664430)
Neal E. Minahan (BBO#661371)
Ada Y. Sheng (BBO#664475)
McDermott Will & Emery LLP
28 State Street
Boston, MA 02109
Tel: (617) 535-4000
Fax: (617) 535-3800

CERTIFICATE OF SERVICE

I hereby certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) on March 24, 2008.

/s/ Emily E. Smith-Lee
Emily Smith-Lee

EXHIBIT 1

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UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
No 1:00-cv-12455-MLW

MICHELLE KOSILEK
Plaintiff

vs

THE MASSACHUSETTS DEPARTMENT OF CORRECTION et al
Defendants

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For Trial Before:
Chief Judge Mark L Wolf

United States District Court
District of Massachusetts (Boston)
One Courthouse Way
Boston Massachusetts 02210
June 7 2006

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REPORTER: RICHARD H ROMANOW RPR
Official Court Reporter
United States District Court
One Courthouse Way Room 5200 Boston MA 02210
(617) 737-0370

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APPEARANCES

FRANCES S COHEN ESQ
JOSEPH L SULMAN ESQ
Dechert LLP
Hancock Tower
200 Clarendon Street
Boston Massachusetts 02116
(617) 728-7173
Email: Frances cohen@dechert com
For Plaintiff

RICHARD C McFARLAND ESQ
JOAN T KENNEDY ESQ
Department of Correction
70 Franklin Street Suite 600
Boston Massachusetts 02110
(617) 727-7403
Email: Rcmcfarland@doc state ma us
For the Defendant Department of Correction

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PROCEEDINGS

(Open court 9:30 a m)

THE CLERK: Civil Action 00-12455 Michelle Kosilek versus Kathleen Dennehy et al The Court is in session You may be seated

THE COURT: Good morning Would counsel please identify themselves for the record

MS COHEN: Good morning your Honor Frances S Cohen and Joseph L Sulman for the plaintiff Michelle Lynn Kosilek and Miss Kosilek is seated with us at counsel table

MR McFARLAND: Good morning your Honor Richard McFarland with co-counsel Joan Kennedy on behalf of the Commissioner of Correction Kathleen Dennehy

THE COURT: I apologize for coming in late but I received submissions from each of you since we recessed yesterday and I needed to take a look at them The plaintiff has 14 hours and 2 minutes left The defendants have 19 hours and 25 minutes left I have received the defendants' memo regarding Rule 404(b) which I've looked at but not that closely yet This morning I received -- and I think it was filed about 11:00 last night the plaintiff's memo regarding collateral estoppel which I have looked at somewhat more closely because I think it relates to the

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A. Well we don't require anything We don't set any standards Our position right from Day 1 in 1971 to today is to maintain a neutral position with regard to these decisions We neither advocate for nor do we speak against the decisions for the cross-gender hormones or eventually for surgery We believe that those decisions are the province of the patients, therefore we don't set standards We don't In a sense, make recommendations We leave the decision making in the hands of the patients

Q Doctor would you send a letter to a surgeon in say Montreal suggesting that this person have Sex Reassignment Surgery --

MS COHEN: Objection

THE COURT: I'm sorry What's the next question?

MS COHEN: I have an objection

THE COURT: Oh, I'm sorry I'm reading something Excuse me

MS COHEN: My objection is to the vagueness of the question The witness has been asked "would he" I don't know in what circumstances the question, does he has he, is it his practice?

MR McFARLAND: I'll rephrase the question

THE COURT: Thank you

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Q Dr Schmidt if a client that you had been evaluating asked you to send a letter to a surgeon recommending that this individual receive the Sex Reassignment Surgery what would be your response to that request?

A It would be that we would not make recommendations what we would do is we would -- with the permission of the patient we would release our file and also indicate that there were no contraindications from our point of view for the surgery if indeed that was the case

Q And Doctor how often in your practice has that happened that you sent a letter to a surgeon providing information to that surgeon about the patient's treatment with your group?

A Well earlier on we probably did that fairly frequently In the last two decades, I would say that the way the practice has evolved since we referred the patients for the psychotherapy If you will during the now real-life period where they're living and functioning in the cross-gender role while on hormones preparing themselves for surgery we usually let the individual -- not usually we let the individual psychotherapist If they're within our faculty do that letter and, of course if the patients come from elsewhere that responsibility would fall to the person

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who's doing that management not to us So we've not been in -- our practice is such that we're not asked to nor do we send those letters very frequently

Q And, Doctor are you familiar with the work of Dr George Brown in the diagnosis and treatment of gender dysphoria?

A Yes I am

Q Would you agree with Dr Brown's opinion that there is no known biological cause of gender dysphoria?

A Yes, I do

Q Would you also agree with Dr Brown's opinion that there is no known genetic cause for the disorder known as GID?

A Yes, I do

Q Would you agree with Dr Brown's opinion that there are no known psychological tests presently available to confirm the diagnosis of a Gender Identity Disorder?

A That is accurate

Q Would you also agree with Dr Brown that often the diagnosis for a GID individual is done primarily through the self-reports of the individual?

A Yes

MS COHEN: Objection to the characterization of Dr Brown

THE COURT: Without the -- well, why don't you

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ask without the preamble

Q Doctor would you agree that the diagnosis of an individual for a Gender Identity Disorder is done primarily through the self-reports of the individual?

A Yes, as it If you will is filtered through the evaluation process done by a professional

Q And would you agree that it's not uncommon for individuals seeking treatment for a Gender Identity Disorder to provide or to rely on their self-reports or to exaggerate their symptoms in hopes of getting treatment?

MS COHEN: Now I'm going to object your Honor to the leading of this witness

THE COURT: Sustained

Q Doctor when you examined an individual for -- a treatment for the symptoms of gender dysphoria were there certain things that you looked for in your evaluation?

A What we looked for -- yes we look to their history for very specific things that help make the diagnosis

Q And, on occasion do you ever seek a third-party to confirm the statements of the individual?

A From time to time we've had the opportunity to have a -- family members if you will who can provide additional data and observations about the earlier

history But I would say the typical patient comes by himself and often they're the only source of the information

Q Doctor are you familiar with the term "dysphoria" as used with regard to gender disorders?

A Yes I am

Q And where is that term defined if you know in any of the manuals that discuss gender dysphoria?

A Well it's a clinical term your Honor that is -- I forget the person who coined the term It's descriptive of the -- if you will the concerns the frustrations sometimes the depression um dissatisfaction etc associated with believing that the -- the patients believe that they are really of the other sex and want to live in the role of the other sex That term is not part of the diagnostic nomenclature within DSM-IV the DSM-IV being the diagnostic manual and there s a section in that manual that sets out the criteria for diagnosing GID Gender dysphoria is not a component of those criteria

Q And Doctor do you diagnose your patients with differing degrees of gender dysphoria?

A No

Q You don't describe them as moderate medium or severe gender dysphoric?